FORM QRI-1 · VERSION 1.0

Patient Care Report Quality Review Instrument

The PCR Under the Microscope
Missouri Ambulance Association • 2026 Fall Seminar

SCOPE OF THIS INSTRUMENT

This is a clinical quality improvement instrument. It is prepared for reporting to the agency's listed patient safety organization within its patient safety evaluation system, and it is not the agency's compliance, coding, or billing audit tool. Medical necessity, signature-for-billing, mileage, and level-of-service determinations are deliberately absent and belong on a separate instrument with a separate owner and a separate file, because information collected to satisfy an external obligation cannot be patient safety work product. Completing this form does not correct the patient care report, and no reviewer edits the record as a result of a finding on it.

Case identification

REVIEW ID		**DATE OF REVIEW**	
INCIDENT NUMBER		**DATE OF SERVICE**	
REVIEWER ID		**PROTOCOL VERSION IN FORCE**	
SELECTION REASON		**TIME SPENT (MINUTES)**	

Selection reason: enter M (mandatory category), T (trigger, name the trigger), R (random sample), or F (referral, name the source). Reviewer ID rather than reviewer name is used so that instruments can be pooled for agreement calculation without identifying the reviewer.

Blinding and conflict

QUESTION	RESPONSE
Was the reviewer blinded to the identity of the crew?	☐ Yes ☐ No ☐ Not feasible in this agency
Does the reviewer have a supervisory or disciplinary relationship to any crew member on this call?	☐ Yes ☐ No
If yes to the preceding question, was the case reassigned?	☐ Yes ☐ No, and the reason is recorded in the comments

PART 1 Explicit criteria

Score every item. M means met, NM means not met, NA means not applicable. There is no partial credit: where a criterion lists several required elements, a single missing element makes the item not met. Do not score from memory of the call, knowledge of the crew, or knowledge of the patient's eventual outcome.

#	SECTION 1.1 ENCOUNTER FRAMING AND DISPOSITION	M	NM	NA
1	**Dispatch information is recorded** Met when a complaint or nature of call appears in plain language, in the dispatch field or the narrative. A numeric determinant code alone is not met.			
2	**Required times are present and in sequence** Dispatch, en route, on scene, at patient, depart scene, at destination, and transfer of care are populated and non-decreasing. Any blank or out-of-sequence time is not met. NA only where the unit was cancelled before patient contact.			
3	**Chief complaint is recorded in the patient's or a bystander's own terms** A subjective complaint distinct from the dispatch complaint and from the provider impression. Not met where the only complaint recorded is the crew's impression.			
4	**History of present illness is developed** Onset is documented plus at least three of: provocation, quality, radiation, severity, time course, associated symptoms. NA where no historian was available and the record states so.			
5	**At least one pertinent negative is documented** A negative finding relevant to the complaint or to the differential the governing protocol addresses.			
6	**History, medications, and allergies are addressed** Each of the three is populated or affirmatively marked unknown or unobtainable. A blank field is not met.			
7	**Transfer of care is documented** Receiving facility, receiving clinician by name or role, time of transfer, and a statement that verbal report was given. NA on non-transport.			
8	**Authorship and timeliness are sound** The report is authored by a crew member who provided care and was completed within the agency's policy window. Any amendment is identified as an amendment with author and date. An unmarked post-hoc change is not met.			

#	SECTION 1.2 ASSESSMENT AND VITAL SIGNS	M	NM	NA
9	**A complete initial set of vital signs is recorded** Blood pressure, pulse, respiratory rate, oxygen saturation, and mental status or Glasgow Coma Scale. Four of five is not a set. NA where the patient refused or condition precluded and the record says so.			
10	**At least two complete sets are recorded on transported patients** Sets at least five minutes apart. NA on non-transport.			
11	**A set is recorded within ten minutes of transfer of care** NA on non-transport.			
12	**Pain is assessed on a numeric or age-appropriate scale** Required where the patient reports pain or the mechanism or complaint suggests it. NA where neither condition is present.			
13	**Blood glucose is documented** Required for altered mental status, seizure, suspected stroke, or a documented diabetic history. NA where none applies.			
14	**Physical examination addresses the systems relevant to the complaint** A template marked entirely unremarkable, with no complaint-specific finding either positive or negative, is not met.			

#	SECTION 1.3 TREATMENT AND REASSESSMENT	M	NM	NA
15	**Every medication carries its full record** Name, dose, route, time, and administering clinician. A missing element on any single medication makes the item not met. NA where no medication was given.			
16	**Every procedure carries its full record** Time, performing clinician, and outcome or success. NA where no procedure was performed.			
17	**Reassessment follows every intervention** The reassessment records the parameter the intervention targets, not merely a repeat vital sign set. Any intervention without a matching reassessment makes the item not met.			
18	**Cardiac monitoring and twelve-lead findings are documented** Rhythm interpretation and, where a twelve-lead was obtained, the interpretation and the time. NA where the protocol did not call for it.			
19	**Any protocol deviation is identified and explained** The record names the deviation, the reason, and any medical control contact and order. NA where care followed protocol.			

#	SECTION 1.4 NARRATIVE CONSTRUCTION	M	NM	NA
20	**The narrative is chronological and covers dispatch through transfer of care** A reader can follow the encounter from arrival to handoff without reordering events.			
21	**Only agency-approved abbreviations appear** Any abbreviation outside the approved list, or any abbreviation on the prohibited list, is not met.			
22	**No conclusory characterization of the patient appears without the observation supporting it** Terms such as intoxicated, uncooperative, drug seeking, malingering, or noncompliant require the documented observations that support them. The label alone is not met.			
23	**No content conflicts with this encounter through copy-forward or template carryover** Content describing a different patient, a different encounter, or an intervention not performed is not met.			
24	**Spelling and clinical terminology do not create ambiguity** The threshold is meaning, not style. An error that changes or obscures clinical meaning is not met.			

PART 2 Conditional modules

Score a module only when the encounter triggers it. Mark the trigger below, then complete the corresponding module. Conditional modules are scored and reported separately from the Part 1 composite, because the triggered denominator differs from case to case and blending the two produces a number that cannot be compared across months.

MODULE	TRIGGERED BY	APPLIES TO THIS CASE
R Refusal and non-transport	Any patient contact not resulting in transport by this unit	☐ Yes ☐ No
A Advanced airway	Any supraglottic or endotracheal airway attempt, successful or not	☐ Yes ☐ No
C Cardiac arrest	Any patient receiving chest compressions by any provider	☐ Yes ☐ No
S Restraint or chemical sedation	Any physical restraint applied or sedative administered for behavioral control	☐ Yes ☐ No
P Pediatric medication	Any medication administered to a patient under 18 years	☐ Yes ☐ No
D Controlled substance	Any scheduled medication administered or wasted	☐ Yes ☐ No

#	MODULE R REFUSAL AND NON-TRANSPORT	M	NM	NA
R1	**Capacity is documented by findings, not by conclusion** The record documents orientation, the absence of an impairing condition, and the patient's ability to describe the situation. The statement that the patient had capacity, standing alone, is not met.			
R2	**Risks are disclosed in specific terms** The specific harms discussed are recorded, including death or serious harm where the presentation warrants it. Risks explained, standing alone, is not met.			
R3	**Alternatives are offered and recorded** At least two of: transport to an alternative destination, transport by other means, contact with a physician, or a return call if the condition changes.			
R4	**The patient's own statement of understanding is recorded** In the patient's words or as a specific paraphrase of what the patient said back.			
R5	**Medical control or supervisory contact is documented where protocol requires it** Name of the contact, time, and any instruction given. NA where the protocol does not require contact for this presentation.			
R6	**Signature is obtained or the failure to obtain one is explained** Signature of the patient or an authorized representative, or a documented reason it could not be obtained, with a witness identified.			

#	MODULE A ADVANCED AIRWAY	M	NM	NA
A1	**Indication for the airway is documented** A clinical finding, not a procedure name.			
A2	**Attempts are fully accounted for** Number of attempts, the clinician performing each, device and size. An attempt is any insertion of the device past the teeth or the lips.			
A3	**Placement is confirmed by waveform capnography** The confirmation method, a recorded value, and the time. NA only where the agency does not carry waveform capnography, which is recorded as an equipment finding.			
A4	**Placement is reconfirmed after each patient move** Move includes onto the cot, into the ambulance, and onto the receiving bed.			
A5	**Physiologic state before and after the attempt is recorded** Oxygen saturation immediately before and after, and blood pressure where obtained.			

#	MODULE C CARDIAC ARREST	M	NM	NA
C1	**The start of resuscitation is anchored in time** Time of arrest recognition, time compressions began, and who began them: bystander, first responder, or this crew.			
C2	**Rhythm is documented initially and at each change** Each rhythm with its time.			
C3	**Each defibrillation is documented** Time and energy for each shock. NA where no shock was delivered.			
C4	**CPR quality data is referenced where the device records it** Compression fraction, rate, or depth summary, or a statement that the data was uploaded. NA where the equipment does not record it.			
C5	**The termination or transport decision is supported** The criteria met or the medical control order, with the time and the ordering physician.			

#	MODULE S RESTRAINT AND CHEMICAL SEDATION	M	NM	NA
S1	**The behavior necessitating restraint is described in observed terms** What the patient did, not how the patient was labeled.			
S2	**Less restrictive measures are addressed** Measures attempted, or the reason they were not attempted.			
S3	**The restraint applied is fully described** Type, time applied, and the limbs or method. Prone positioning, if used, is specifically addressed.			
S4	**Circulation, airway, and respiratory checks are documented at the required interval** Each check with its time. A single check is not met where the protocol requires repetition.			
S5	**Monitoring after sedation is documented** Continuous oxygen saturation and, where the protocol requires it, waveform capnography. NA where no sedative was given.			

#	MODULE P PEDIATRIC MEDICATION	M	NM	NA
P1	**Weight is documented in kilograms with its source** Scale, length-based tape, or caregiver report. A weight in pounds only is not met.			
P2	**The dose is expressed per kilogram and as a total** Both figures appear.			
P3	**The total dose falls within the protocol range for the documented weight** Recalculate. A dose outside range is not met and triggers Part 4 regardless of outcome.			
P4	**Length-based tape color is recorded where the tape was used** NA where the tape was not used.			

#	MODULE D CONTROLLED SUBSTANCE	M	NM	NA
D1	**Amount administered and amount wasted are both documented** Both figures, in the record and not only in the drug log.			
D2	**Waste is witnessed and the witness is identified** By name or identifier. NA where nothing was wasted.			
D3	**The record reconciles to the controlled substance log** Reviewer confirms the entry exists in the log and matches. A mismatch is not met and is referred immediately.			

PART 3 Anchored judgments

Four judgments. The first three are scored one through five using the written anchors below; scores of two and four fall between the anchors on either side. Anchors exist because an unanchored rating scale produces noise rather than measurement, and because a score assigned against a written anchor can be adjudicated when two reviewers disagree. Score every judgment even where Part 1 was fully met, and record a comment for any score of three or below.

J1 Circle one	Narrative sufficiency: could a clinician who was not present reconstruct this encounter from the record alone?		
SCORE 1 2 3 4 5	**1** The encounter cannot be reconstructed. Material decisions are unexplained, or no documented finding supports what was done.	**3** What was done can be reconstructed, but why it was done must be inferred. One or two material gaps.	**5** Condition, its evolution, the reasoning behind each decision, and the patient's state at transfer are all reconstructable without asking a question.

J2 Circle one	Congruence: does the documented care follow from the documented findings and the governing protocol?		
SCORE 1 2 3 4 5	**1** Documented care conflicts with documented findings or with protocol, and nothing in the record explains the conflict.	**3** Care is broadly appropriate, but at least one intervention or one omission is unexplained by anything in the record.	**5** Every intervention is supported by a documented finding, and every documented finding calling for action was acted on or the deviation is explained.

J3 Circle one	Defensibility: how would this record perform as an exhibit if the encounter were litigated?		
SCORE 1 2 3 4 5	**1** The record would damage the agency: internal contradictions, opinion presented as fact, disparaging language, or apparent after-the-fact justification.	**3** Generally defensible, but contains conclusory statements, unsupported labels, or inconsistencies that a cross-examiner would use.	**5** Factual, observation-based, internally consistent, and free of editorializing. Every conclusion in the record is supported by something else in the record.

J4. Patient safety signal

Independent of documentation quality. Judge the encounter, not the chart. A perfectly documented encounter can carry a safety signal, and a poorly documented encounter usually does not.

SELECT ONE	DEFINITION	ROUTING
☐ **No signal**	Nothing in the encounter suggests a hazard to this or a future patient.	None
☐ **Unsafe condition**	A hazard was present but no error occurred: an expired supply, a missing device, an ambiguous protocol.	Patient safety evaluation system
☐ **Near miss**	An error occurred but did not reach the patient, or was caught and corrected.	Patient safety evaluation system
☐ **Event, no harm**	An error reached the patient without detectable harm.	Patient safety evaluation system, and Part 4
☐ **Event, harm**	An error reached the patient and harm occurred or plausibly may occur.	Patient safety evaluation system, Part 4, and immediate notification of the quality officer and medical director

PART 4 Accountability classification

Complete this part only where a deficiency was identified. Classify the behavior, not the outcome. The reviewer applies both tests before assigning any individual accountability, and the classification is recorded before the disposition is chosen.

CLASSIFICATION	DEFINITION	RESPONSE	SELECT
Human error	An inadvertent slip, lapse, or mistake. The clinician did not intend the act and did not perceive a risk.	Console. Examine the system that allowed the error.	☐
At-risk behavior	A choice that increased risk, where the risk was not recognized or was mistakenly believed justified. Usually a drift that the system rewarded.	Coach. Remove the incentive to drift and restore awareness of the risk.	☐
Reckless behavior	A conscious disregard of a substantial and unjustifiable risk.	Discipline, through the personnel process, not through this instrument.	☐
No individual behavior at issue	The deficiency is systemic: protocol, equipment, staffing, training, or documentation design.	System action. No individual accountability.	☐

Tests applied before assigning individual accountability

TEST	QUESTION	RESULT
Substitution	Would three peers of similar training and experience, in the same circumstances with the same information, plausibly have done the same thing?	☐ Yes ☐ No
History	Does this clinician have a documented history of the same behavior, addressed through the same process, within the lookback period the policy defines?	☐ Yes ☐ No
Deviation	Was the outcome, rather than the behavior, what drew this case into review?	☐ Yes ☐ No

THE BOUNDARY

A classification of reckless behavior ends this review. The case leaves the quality process at that point and enters the agency's personnel process, where the clinician is entitled to notice and an opportunity to respond. The reviewer records the date and time of the handoff, the person to whom the case was transferred, and nothing further on this form. Analysis generated after the handoff is not created for reporting to the patient safety organization and does not enter the patient safety evaluation system.

PART 5 Disposition and scoring

Disposition

ACTION	WHEN IT APPLIES	SELECT
No action	All Part 1 items met or not applicable, all judgments 4 or 5, no safety signal.	☐
Written feedback only	Isolated documentation findings, judgments 3 or above, no safety signal.	☐
Coaching conversation	A judgment of 3 or below, a pattern across this clinician's prior reviews, or any at-risk classification.	☐
Referral to case conference	Teaching value for the wider agency, whether the case went well or badly.	☐
Referral for event analysis	Any safety signal at near miss or above.	☐
Referral to data quality	Findings that are artifacts of the software or the template rather than of the clinician.	☐
Handoff to the personnel process	Reckless classification, or a controlled substance reconciliation failure.	☐

Score summary

MEASURE	CALCULATION	VALUE
Part 1 composite	Items met divided by items met plus items not met. Items marked not applicable are excluded from the denominator.	
Items not met	Count.	
Items not applicable	Count. A high count signals that the criteria set may not fit this agency's case mix.	
Conditional module score	Reported separately by module. Do not blend into the Part 1 composite.	
Judgment mean	Mean of J1, J2, and J3.	
Judgments at 2 or below	Count. This count, not the mean, drives referral.	
Safety signal	From J4.	

Automatic referral triggers

The reviewer has no discretion on the following. Any one of them refers the case regardless of the composite score.

- Any judgment scored 1
- J3 scored 2 or below

- Any safety signal above no signal
- Any item not met in Section 1.3 item 17, Section 1.4 item 22, or Section 1.1 item 8
- Any item not met in Module R or Module D
- A pediatric dose outside the protocol range under item P3, irrespective of patient outcome

Reviewer attestation

REVIEWER ID		**DATE COMPLETED**	
SECOND REVIEWER ID (IF DOUBLE-ABSTRACTED)		**ADJUDICATION REQUIRED**	
COMMENTS CONTINUED ON ATTACHMENT		**ENTERED INTO REVIEW DATABASE**	

Instrument control

FIELD	ENTRY
Instrument	Form QRI-1, Patient Care Report Quality Review Instrument
Version	1.0
Status	Template for adaptation. An agency adopting this instrument must reconcile every criterion against its own protocols, approved abbreviation list, and documentation policy before use.
Approved by	Medical director signature and date required before operational use
Scheduled review	Annually, and after any protocol revision affecting a scored criterion
Legal posture	Clinical quality improvement instrument prepared for reporting within the agency's patient safety evaluation system. Not a compliance or billing audit tool.